Supreme Court, U.S.
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No. 96-1365

In The

Supreme Court of the United States

October Term, 1996

VALERIE MILLER and VICKIE WILLIAMS, D.O.,

Petitioners,

vs.

ARLENE M. BROWN, M.D., and
FAMILY PRACTICE ASSOCIATES, P.C.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Did Dr. Brown present sufficient evidence to permit a reasonable jury to find that, in revoking Dr. Brown's obstetrics privileges, the hospital failed to make "a reasonable effort to obtain the facts of the matter," as required by 42 U.S.C. § 11112(a)(2), in view of the fact that the revocation followed a review of only two charts, which, by the hospital's admission, did not reflect any departure from the standard of care?

2. Did Dr. Brown present sufficient evidence to permit a reasonable jury to find that Ms. Miller reported the revocation of Dr. Brown's privileges as based on "Incompetence/Malpractice/Negligence" knowing that the report was false, such that Ms. Miller was not entitled to immunity under 42 U.S.C. § 11137(c)?

RULE 29.6 LISTING

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RESPONDENTS' BRIEF IN OPPOSITION

Respondents Dr. Arlene M. Brown, M.D. and Family Practice Associates, P.C. (collectively, "Dr. Brown") respectfully request that the Court deny the petition for writ of certiorari submitted on behalf of Ms. Valerie Miller and Dr. Vickie Williams, D.O. (collectively "the Petitioners"). The Petitioners' attempt to depict the Tenth Circuit's decision as creating a split among the circuits concerning the treatment of conflicting expert testimony under 42 U.S.C. § 11112(a)(2) of the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152 ("HCQIA")[1] fails for two reasons.

First, the Petitioners' argument does not account for the unique facts of Dr. Brown's case. One of the central issues at trial was whether the hospital made a reasonable effort to obtain the facts concerning Dr. Brown's knowledge and skill in obstetrics. Without such an effort, the Petitioners are not entitled to HCQIA immunity. As

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[1] 42 U.S.C. § 11112(a) provides HCQIA immunity if the professional review action was taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

explained below, no other court has addressed HCQIA immunity in connection with a revocation of hospital privileges based on a review of only two charts which, by the hospital's admission, reflected no departure from the standard of care. No other case presents a comparable failure to make a reasonable effort to obtain the facts.

The Tenth Circuit correctly applied the "objective reasonableness" standard in holding that these facts would allow a reasonable jury to conclude that the hospital had failed to make "a reasonable effort to obtain the facts of the matter," as required by § 11112(a)(2). For this reason alone, the Tenth Circuit's opinion cannot be fairly characterized as creating a split among the circuits. Instead, the Tenth Circuit addressed and correctly resolved an ordinary "substantial evidence" issue.

Furthermore, the Petitioners' attempt to portray a split rests on precedents applying distinguishable statutory language. The cases the Petitioners rely on articulate a rule for conflicting expert testimony relating to subsections 1 and 4 of § 42 U.S.C. § 11112(a), which both include a "reasonable belief" element. The Tenth Circuit's decision applies subsection 2 of § 11112(a), which contains no "reasonable belief" language and considers only whether the peer review action was taken "after a reasonable effort to obtain the facts of the matter." The Petitioners' efforts to depict a split thus improperly blurs the differences in the language of subsection 2 and subsections 1 and 4.

Finally, the Petitioners seek review of the Tenth Circuit's denial of HCQIA immunity under 42 U.S.C. § 11137(c) for Ms. Miller's report of the revocation of Dr.

Brown's privileges to the National Practitioner Data Bank. The Petitioners do not claim that this part of the Tenth Circuit's decision creates a split among the circuits. Instead, the Petitioners question whether the evidence in this case would allow a reasonable jury to conclude that Ms. Miller made the "Incompetence/Malpractice/ Negligence" report knowing of its falsity. As demonstrated below, the record supports the jury's conclusion that Ms. Miller knew her report was false.

REASONS FOR DENYING THE PETITION

I. The Tenth Circuit's Decision to Deny Immunity for the Revocation of Dr. Brown's Privileges Creates No Split Among the Circuits.

A. The Unique Facts of This Case Dictated Its Outcome.

The Petitioners' argument that the Tenth Circuit's decision creates a split among the circuits disregards the unique facts in this case. The decision to revoke Dr. Brown's obstetrics privileges rested on a review of only two patient charts. App. 20, 35. Dr. Brown's expert, Dr. Lindley, testified that Dr. Brown abided by the consultation requirement,[2] but that in any event, a review of only

[2] Dr. Lindley testified that, in one of the two cases reviewed, Dr. Brown could not have violated the consultation requirement, which was imposed as a restriction on Dr. Brown's hospital privileges, because Dr. Brown treated the patient in question in Dr. Brown's office and not at the hospital. Dr. Brown was therefore not exercising her hospital privileges. The

two charts did not provide a reasonable basis for revoking Dr. Brown's obstetrics privileges or amount to a reasonable effort to obtain the facts. App. 35, 36. Dr. Lindley reviewed the charts for all of the obstetrics patients Dr. Brown treated in the six-month period before her privileges were revoked, a sample consisting of 50 charts. Dr. Lindley conducted this review because he wanted enough information to assess whether Dr. Brown possessed the knowledge and skill to recognize high risk cases. App. 36.

After conducting the 50 chart review, Dr. Lindley had no questions about Dr. Brown's ability to recognize high risk cases and saw no instances where she failed to get a necessary consultation. No other witness provided testimony based on a review of the 50 charts Dr. Lindley examined or a comparable sample. No witness expressly testified that a review confined to the two charts at issue amounted to a reasonable effort to assess Dr. Brown's skills and knowledge in obstetrics. In this area, Dr. Lindley's conclusions were unrebutted.[3]

At trial, the Petitioners' experts confined their conclusions to whether the two charts reviewed reasonably supported the revocation of Dr. Brown's privileges. They did not attempt to defend the limited scope of review. Thus, their testimony addressed only subsection 1, and

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Petitioners' experts agreed. The hospital's "extraterritorial" enforcement of the restriction on Dr. Brown's hospital privileges adds another unique factual dimension to Dr. Brown's case.

[3] The Petitioners' attempt to posit a split among the circuits based on a disagreement between expert witnesses is especially unpersuasive in view of their decision not to offer their own expert conclusions based on a review of the 50 charts Dr. Lindley reviewed.

perhaps subsection 4, of § 11112(a), concerning whether the hospital had a "reasonable belief that the action was in furtherance of quality health care" and whether the hospital had a "reasonable belief that the action was warranted." Despite Dr. Lindley's testimony, the Petitioners' experts did not expressly address whether there had been "a reasonable effort to obtain the facts of the matter."

One of the Petitioners' medical experts, Dr. Messer, agreed that, in making privileges decisions, a reviewer should have as much information about a physician's skill and abilities as possible and that a review of 50 charts is therefore preferable to a review of only two. Dr. Messer reviewed the 50 charts examined by Dr. Lindley, but offered no opinions based on them. Dr. Hutchinson, an OB-GYN specialist testifying for the Petitioners, agreed that two or three charts did not provide a representative sample of Dr. Brown's obstetrics practice and would not provide a sufficient basis for conclusions about Dr. Brown's knowledge of obstetrics.

Dr. Olds, another of the Petitioners' medical experts, admitted that, in his own experience as a reviewer in license revocation proceedings, he examined 25 to 50 preselected "problem" charts. He testified that, in his own experience, revocations based on single cases have occurred, depending on "how bad" the case was.[4]

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[4] The testimony from Drs. Olds, Hutchison, and Messer about the scope of reviews in their real life experiences as peer review participants contrasts sharply with the Petitioners' arguments about the sufficiency of the chart review in Dr. Brown's case. This contrast by itself would allow a reasonable jury to decide that the review was insufficient, irrespective of

The evidence concerning "how bad" Dr. Brown's two cases were also makes the revocation of Dr. Brown's privileges unique among peer review decisions. The hospital revoked Dr. Brown's obstetrics privileges after reviewing only two charts which the hospital itself recognized as not representing any departures from the relevant standard of care. App. 38, 39-40, 70, 71. For example, the hospital's counsel, Mr. Lasater, wrote to Dr. Brown's lawyers shortly after the revocation that

> the issue was not whether, on these occasions [the two charts reviewed], Dr. Brown met the minimum standards required of a family practitioner taking care of a high risk patient. The issue, I believe, was whether Dr. Brown had failed to comply with her agreement to obtain consultations for high risk patients.
>
> App. 86.

Petitioner Dr. Williams agreed at trial that Mr. Lasater's distinction drew a "bright line" separating standard of care issues and the question whether Dr. Brown complied with the consultation requirement. The hospital's Board members agreed. In the Board's view, Dr. Brown's case presented a question of whether Dr. Brown had lived up to her promise, rather than a medical issue. App. 71. Also, Petitioner Dr. Williams testified that she had "no heartburn" with the medical management of the patient Dr. Brown treated at the hospital. App. 70.

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the conflict between the experts. *See, e.g., Barefoot v. Estelle*, 463 U.S. 880, 902-03 (1983); *Powers v. Bayliner Marine Corp.*, 83 F.3d 789, 797-98 (6th Cir.), *cert. denied*, 117 S. Ct. 481 (1996).

The Petitioners have cited no decisions in which a court has upheld a claim for HCQIA immunity under 42 U.S.C. § 11112(a)(2) based on a comparably restricted scope of review. The trial court carefully canvassed HCQIA precedents, contrasting the extent of review and the evidence of deficient or substandard care in those precedents with the review of two charts in Dr. Brown's case. App. 36-37, 82-85.[5] The narrow scope of review and

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[5] The trial court compared the scope of review in Dr. Brown's case with *Mathews v. Lancaster General Hospital*, 883 F. Supp. 1016, 1035 (E.D. Pa. 1995), *aff'd*, 87 F.3d 624 (3rd Cir. 1996); *Monroe v. AMI Hospitals of Texas, Inc.*, 1994 LEXIS 17755 (S.D. Tex., Oct. 27, 1994); *Willman v. Heartland Hospital East*, 34 F.3d 605 (8th Cir. 1994), *cert. denied*, 115 S. Ct. 1361 (1995); *Imperial v. Suburban Hospital Board of Trustees*, 37 F.3d 1026 (4th Cir. 1994); *Bryan v. Holmes Regional Medical Center*, 33 F.3d 1318, 1332 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 1363 (1995); *Rooney v. Medical Center Hospital of Chillicothe, Ohio*, 1994 LEXIS 7420 (S.D. Ohio 1994); *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992); *Oksanen v. Page Memorial Hospital*, 945 F.2d 696 (4th Cir. 1991), *cert. denied*, 502 U.S. 1074 (1992); *Fobbs v. Holy Cross Health System Corp.*, 789 F. Supp. 1054 (E.D. Cal. 1992), *aff'd in part and reversed in part*, 29 F.3d 1439, *cert. denied*, 115 S. Ct. 936 (1995); *Smith v. Ricks*, 798 F. Supp. 605 (N.D. Cal. 1992), *aff'd*, 31 F.3d 1478 (9th Cir. 1994), *cert. denied*, 115 S. Ct. 1400 (1995); *Islami v. Covenant Medical Center, Inc.*, 822 F. Supp. 1361, 1365 (N.D. Iowa 1992). The same comparison with more recent cases confirms the uniquely narrow scope of review in Dr. Brown's case. *See Goodwich v. Sinai Hospital of Baltimore, Inc.*, 680 A.2d 1067 (Md. 1996) (revocation of privileges followed years of discussion and correspondence with physician about patient care problems, physician's repeated failures to heed written warnings about necessity of obtaining second opinions, and failure to obtain second opinions in more than a dozen high risk cases); *Johnson v. Greater Southeast Community Hospital Corp.*, 1996 WL 377147 (D.D.C. June 24, 1996) (review of seven cases over a nine month peer review process revealed very serious quality of care

the defendants' admissions that the treatment reflected in the two charts reviewed did not depart from the standard of care distinguish this case from the decisions Petitioners cite. Thus, no split among the circuits exists because no other court has considered HCQIA immunity under 42 U.S.C. § 11112(a)(2) in light of a similarly limited scope of review, with comparable concessions that the case against the plaintiff/practitioner represented no departures from the standard of care, and with a comparable lack of rebuttal to the plaintiff's expert's conclusions.

The Tenth Circuit and the district court correctly applied the standard controlling the availability of HCQIA immunity in determining that, based on these facts, Dr. Brown had presented sufficient evidence for a reasonable jury to find, by a preponderance of the evidence, that the peer review action was not taken after a "reasonable effort to obtain the facts of the matter." App. 20. In doing so, the Tenth Circuit and the district court applied an objective standard of reasonableness. App. 19, 21, n.9 (applying objective standard articulated in *Mathews v. Lancaster General Hospital*, 87 F.3d 624, 634 (3d Cir. 1996) and *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992)), App. 34-37. The outcome of Dr. Brown's case thus derived from the unique facts it presented, not from some aberrant misapplication of the law.

Also, the unique facts of this case defeat the Petitioners' claim to HCQIA immunity irrespective of

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concerns related to potentially life threatening surgical complications and several major surgeries without adequate indications).

whether conflicting expert testimony about the reasonableness of the scope of inquiry creates a triable issue of fact under § 11112(a)(2). The Petitioners' position disregards the fact that the evidence in this case sufficed to permit the jury to find that Dr. Brown had overcome all three of the disputed HCQIA elements. *See* App. 21, n.9, App. 32-37.

B. The Petitioners' Argument Rests on Distinguishable Precedents.

In addition to ignoring the unique facts in Dr. Brown's case, the Petitioners overlook the difference between the statutory basis for the Tenth Circuit's decision and for the decisions they rely on in positing a split among the circuits. The Petitioners have cited no decisions in which a court analyzing the "reasonable effort to obtain the facts" requirement imposed by § 11112(a)(2) has held that a disagreement among experts is insufficient to create a triable fact question.[6] For this reason, the Tenth Circuit's decision does not conflict with any other circuit court precedents, including those analyzing the effect of conflicting expert testimony under the portions of § 11112(a) which include a "reasonable belief" element.

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[6] The precedent coming closest to such a holding, *Mathews*, 87 F.3d at 635, analyzes conflicting expert testimony only under §§ 11112(a)(1) and (4). *Id.* at 636 n.9, 638. The *Mathews* court did not address the absence of a "reasonable belief" element in subsection 2. In holding that the defendants had met the requirements of subsection 2, the *Mathews* court relied on a review process which examined 208 cases, lasted over two years, and disclosed 23 instances of substandard care. *Id.* at 637, 630-31.

The Petitioners' argument rests on cases applying subsections 1 and 4 of § 11112(a), which both include a "reasonable belief" element. Petition at 13-15. The Tenth Circuit, however, concluded that the Petitioners were not entitled to immunity because the jury could reasonably have concluded that the hospital did not satisfy subsection 2 of § 11112(a), which does not consider the "reasonable belief" of the peer review participants. Instead, § 11112(a)(2) requires that the peer review action must be taken "after a reasonable effort to obtain the facts of the matter," with no allowance for the peer review participant's belief that the effort to obtain the facts was reasonable. App. 37.

Thus, the Petitioners disregard the difference between the language of subsections 1 and 4 and the language of subsection 2 in attempting to depict a split among the circuits. The language of subsection 2 forecloses the Petitioners' reliance on cases holding that HCQIA immunity is available if the defendant acted in the reasonable belief that the peer review action was proper, Petition 16, or unavailable only where the plaintiff shows that no reasonable reviewer could have believed the action was warranted. Petition 18-19.

The extremity of the Petitioners' argument deserves emphasis. If the Petitioners are correct, conflicting expert testimony is always insufficient, regardless of the circumstances, to create a fact issue under any of the § 11112(a) standards, with the possible exception of subsection 3, relating to notice and hearing. Other HCQIA decisions appear to foreclose reliance on evidence of subjective bad faith, malice or anticompetitive motives. *See, e.g., Bryan*, 33 F.3d at 1323; *Austin*, 979 F.2d at 734. The combined

effect of these decisions and the Petitioners' interpretation of § 11112(a) would be that a plaintiff facing a claim of HCQIA immunity could rebut the presumption of reasonableness only with evidence of inadequate notice or hearing. The Petitioners' position would therefore make HCQIA immunity essentially absolute, a result Congress clearly did not intend in creating qualified immunity based on a rebuttable presumption of reasonableness. *See, e.g., Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 332, n.12 (1991) (quoting legislative history of HCQIA stating that "[t]he immunity provisions [were] restricted so as not to protect illegitimate actions taken under the guise of furthering the quality of health care. Actions . . . that are really taken for anticompetitive purposes will not be protected under this bill."); App. 21, n.9.

Congress did not intend to grant absolute immunity to any defendant who hires an expert. The Petitioners, in attempting to make HCQIA immunity essentially absolute by importing the "reasonable belief" element into subsection 2, disregard the plain language of the statute. *See West Virginia University Hospitals, Inc. v. Casey*, 499 U.S. 83, 98 (1991) (text of the statute is the best evidence of Congressional intent). The effect the Petitioners argue for would require an amendment to the HCQIA. *See Patrick v. Burget*, 486 U.S. 94, 105, n.8 (1988) ("If physicians believe that the Act [HCQIA] provides insufficient immunity to protect the peer review process fully, they must take that matter up with Congress."). Under the plain language of subsection 2, Dr. Lindley's unrebutted conclusion that the hospital unreasonably restricted the scope of review in Dr. Brown's case by examining only two charts defeated HCQIA immunity.

II. The Tenth Circuit Correctly Found That A Reasonable Jury Could Have Concluded That Ms. Miller Knew Her Report To The National Practitioner Data Bank Was False.

The Petitioners do not claim that the Tenth Circuit's denial of HCQIA immunity to Ms. Miller under 42 U.S.C. § 11137(c)[7] creates a split among the circuits. Instead, the Petitioners seek review of the defamation verdict because they believe that the Tenth Circuit improperly applied § 11137(c) in holding that the evidence that Ms. Miller made the report with knowledge of its falsity was sufficient to overcome HCQIA immunity. Petition 23-26.

Again, the Petitioners' argument seeks certiorari to revisit a garden variety "substantial evidence" issue. The record in this case more than suffices to show that Ms. Miller knew of the falsity of her "Incompetence/Malpractice/Negligence" report. Neither the review panel nor the hospital's Board ever made a finding of incompetence, malpractice or negligence on Dr. Brown's part. App. 22. Ms. Miller knew no such finding had been made. App. 22. Ms. Perry, who assisted Ms. Miller in selecting the code designation for the report, told Ms. Miller that she was concerned about its accuracy. App. 38-39. When Dr. Brown disputed the report, the Data Bank gave the hospital the opportunity to revise the code designation, but the hospital declined. App. 39. Also, Ms. Miller received a copy of Mr. Lasater's letter distinguishing between standard of care issues and the issue presented in Dr. Brown's

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[7] Section 11137(c) states that "[n]o person . . . shall be liable . . . with respect to any report made under this subchapter . . . without knowledge of the falsity of the information contained in the report."

case concerning whether Dr. Brown had violated her consultation requirement. App. 39.

In view of this record, the Tenth Circuit's denial of § 11137(c) immunity accords with the plain meaning of the phrase "without knowledge of the falsity of the information contained in the report." Dr. Brown presented enough evidence to allow a reasonable jury to decide that Ms. Miller made a false report with knowledge of its falsity. The punitive damage award against Ms. Miller underscores the strength of the record revealing her improper motives.

CONCLUSION

The Court should deny the Petitioners' request for a writ of certiorari.

Respectfully submitted,

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